American Society of Addiction Medicine

4601 North Park Avenue ● Upper Arcade Suite 101 ● Chevy Chase, MD 20815-4520
Treat Addiction ● Save Lives

June 9, 2015

Andy Slavitt
Acting Administrator
Centers for Medicare and Medicaid Services
7500 Security Boulevard
Baltimore, MD 21244

RE: CMS-2333-P, Medicaid and Children's Health Insurance Programs; Mental Health Parity and Addiction Equity Act of 2008; the Application of Mental Health Parity Requirements to Coverage Offered by Medicaid Managed Care Organizations, the Children's Health Insurance Program (CHIP), and Alternative Benefit Plans

Dear Acting Administrator Slavitt,

The American Society of Addiction Medicine (ASAM) is pleased to have the opportunity to comment on the Proposed Rule on the application of mental health parity requirements to coverage offered by Medicaid Managed Care Organizations (MCOs), the Children's Health Insurance Program (CHIP), and Alternative Benefit Plans (ABP).

Established in 1954, ASAM represents more than 3,200 physicians and associated professionals dedicated to increasing access and improving the quality of addiction treatment. On a daily basis, our members encounter the many barriers patients face when attempting to access treatment for addiction, including onerous prior authorization requirements, fail first requirements, time and dosage limitations on medication, and other restrictions on treatment that are not commonly or not equally applied to treatment services for other medical conditions. As such, we feel uniquely qualified to comment on the provisions of this proposed rule that have the potential to increase patient access to mental health and substance use disorder treatment.

Unfortunately, a long history of insurance discrimination against those with mental health and substance use disorders (MH/SUD) has prevented many individuals from receiving the clinically appropriate care needed to get and stay well. There is also an unacceptably large treatment gap for MH/SUD. In 2013, 20.2 million Americans were identified as needing treatment for a substance use disorder, but did not receive it.[1] Research has revealed this treatment cap exists among Medicaid beneficiaries, too. A 2013 analysis found that only 46.8% of Medicaid enrollees with a need for substance use disorder treatment had received any treatment, compared to 31.3% of demographically similar

Phone: (301) 656-3920 ● Fax: (301) 656-3815
E-mail: email@asam.org ● Website: www.asam.org

uninsured individuals. When the analysis excluded informal care received outside the medical sector, treatment rates were much lower: 12.8% in the uninsured group and 30.7% in the currently enrolled group.[2]

The implementation and enforcement of this proposed rule holds great promise to reduce this treatment gap significantly and ensure equitable access to treatment for persons with mental illness and substance use disorders. In light of the enormous economic costs and, more importantly, the human toll that substance use disorders exact upon our nation, it is imperative that this rule provide comprehensive protections for patients, be enacted swiftly and be enforced publicly.

KEY PROVISIONS IN THE PROPOSED RULE

- **We applaud CMS for the comprehensive approach it has proposed in applying MHPAEA parity protections for MH/SUD state plan services to all Medicaid MCO enrollees**, whether or not those MH/SUD services are provided by the MCO or through another service delivery system such as a prepaid inpatient health plan (PIHP), prepaid ambulatory health plan (PAHP), or under Medicaid FFS. We agree with CMS that regulations that do not apply parity to carve-out arrangements would eliminate the application of parity in states with such arrangements, and thus would greatly reduce the impact of the regulations and would not be consistent with what Congress intended when they passed the law in 2008.

- **We support CMS's proposal not to include an increased cost exemption for MCOs, PIHPs, or PAHPs, and support building any increased costs associated with parity into the state's rate setting structure**.

  The regulations governing MHPAEA's application to commercial health insurance exempt health plans that incur an increased cost of at least two percent in the first year that parity's requirements apply, or incur an increased cost of at least one percent in any subsequent plan or policy year. To our knowledge, no health plan in the commercial market has been able to demonstrate increased costs that are sufficient to gain an exemption, and no exemptions have been given. We appreciate that CMS agrees that an increased cost exemption is not needed for parity compliance in Medicaid and CHIP.

  We also appreciate that CMS proposes to include any costs of parity compliance in the state's rate setting structure. We believe that any costs associated with bringing Medicaid and CHIP coverage into compliance with parity will be minimal. We also believe, as does CMS, that proper implementation of parity may well save money as more beneficiaries will be able to access appropriate care for their MH/SUD conditions, resulting in fewer emergency department visits and hospitalizations as well as improved physical health. Building any costs associated with adding services or removing treatment limitations into the actuarially sound rate methodology is appropriate, and we believe that the proposed language is sufficient to limit rate setting to only include the services necessary to meet state plan and parity obligations.

- **We support the proposal to apply the requirements imposed on the health insurance issuer through the MHPAEA final regulations regarding availability of information in a similar manner to MCOs and to PIHPs and PAHPs that provide coverage to MCO enrollees**. Clear and timely information regarding medical necessity criteria and reasons for denial of coverage is crucial for enrollees, potential enrollees and contracting providers to understand their benefits and appeal decisions if needed, as well as for enforcement of this regulation.

PROPOSED MODIFICATIONS FOR INCLUSION IN THE FINAL RULE

While we support the overall approach CMS has proposed in applying MHPAEA parity protections to Medicaid MCO, CHIP and ABP enrollees, ASAM members respectfully offer the following recommendations and request additional clarity on certain issues.

- **Reduce the time required for states to come into compliance with these regulations to 12 months after the rule is finalized**, with an exemption for only those states that must obtain approval of budget changes and whose legislatures are not scheduled to meet during that year.

  Congress passed MHPAEA in 2008. Final regulations governing parity in the commercial health insurance market were not released until 2013, and these proposed regulations for Medicaid and CHIP were released more than five years after the last congressional action on parity. While we understand that our health care system is undergoing historic changes and that there have been significant demands placed on HHS and states to develop and implement regulations governing the future of health policy, we feel that affording all states 18 months after the rule is finalized to come into full compliance is excessive and further delays the implementation of protections for enrollees that Congress approved nearly a decade ago. This is far too much time, and we strongly encourage CMS to implement this rule as quickly as possible.

  CMS has explained that states require 18 months from the finalization of the rule to bring their programs into compliance, because managed care contracts may need to be revised and state legislative action may be required before a states can come into compliance with the regulations. While we understand that states often need time to implement significant changes to their Medicaid and CHIP programs, states have known for many years that parity applied to these programs and that these programs needed to be generally in compliance, even absent regulations.

  Through the November 4, 2009 State Health Official Letter[3], CMS clearly indicated to states that their Medicaid and CHIP plans needed to meet parity requirements before the issuance of these proposed regulations. Additionally, section 3(d)(2) of the CHIP Reauthorization Act made it clear that states were required to make a good faith effort in both their Medicaid and CHIP programs to comply with the requirements prior to the issuance of any regulations or risk losing federal financial participation. And Medicaid

ABPs that have been implemented since the passage of the ACA, including all ABPs implementing the ACA's Medicaid expansion, have had to comply with parity. CMS has repeatedly told states of the parity compliance requirement for these plans.

Because parity has already been in effect for Medicaid and CHIP plans absent the regulations, states should only need to implement the provisions of the regulations that differ in approach or detail from the guidance that has already been given them by CMS. Therefore, we believe that full compliance should take no longer than 12 months from finalization of the rule for all or almost all states, and most states should be able to comply much sooner. We encourage CMS to shorten the timeline for compliance from 18 months from finalization to no more than 12 months, unless a state can demonstrate to CMS that meeting the requirements of the final rule in 12 months is not possible. If a state can demonstrate the genuine need for the full 18 months, CMS could extend the implementation deadline for that state, but only if that state can show that it continues to make strong progress implementing parity in the interim.

In addition, we ask CMS to include in the final rule "benchmarks" that all states must meet to show progress in implementing the regulation between release of the final rule and the day it goes into effect. Such benchmarks should include:

- A requirement that MCO, PIHP or PAHP contracts, as applicable, be submitted for review within 6 months after the rule is finalized;
- A requirement that states submit progress report with their plan to bring its coverage into compliance within 6 months after the rule is finalized;
- An offer of technical assistance (TA) from CMS to states who need additional technical guidance to bring their state plans or MCO, PIHP or PAHP contracts into compliance; and
- A requirement that contracts and progress reports be posted on the CMS website.

- **Clearly define the term "long term care" to exclude long-term treatment for substance use disorders and other chronic mental illnesses, including necessary medication maintenance therapy, psychosocial recovery supports and counseling**.

  It is proposed that "the definition of 'medical/surgical services' clearly exclude long term care services in the Medicaid and CHIP context." The rationale given for this exclusion is that such a clarification would be consistent with the intent of the MHPAEA final regulations, as the kinds of long term care services included in benefit packages for Medicaid and CHIP beneficiaries are not commonly provided in the commercial market as part of health benefits coverage.

  The proposed rule goes on to say that "long term care services and supports, such as personal care, home and community based services, or long term psychosocial rehabilitation programs, are also commonly included in benefit packages for all or

targeted populations of Medicaid and CHIP beneficiaries, but these benefits are not typically provided in a commercial environment" and therefore long term care services are not to be included in one of the classifications of benefits. Finally, the terms "mental health benefits" and "substance use disorder benefits" as defined in the proposed rule do not include long term care MH and SUD benefits.

While we appreciate the desire for consistency between the regulations applying parity to the commercial market and regulations applying parity to Medicaid and CHIP, we believe that the regulations must reflect the differences between commercial insurance and Medicaid/CHIP, as well as the different needs of the populations that each type of health coverage serves. We do not believe that parity only applies to Medicaid/CHIP services that are typically also covered by commercial insurance. Rather, we believe that parity applies to all covered benefits in Medicaid and CHIP, and that parity applies to all benefits covered by a commercial health plan.

If CMS implements its proposed approach to exclude long term care services from parity requirements, we ask for much more detail on which long term care services are excluded and assurances that excluding those services will in no way limit the application of parity to the full range of MH/SUD services across the prevention, treatment, recovery, and rehabilitative continuum for these illnesses. In particular, we have serious concerns that the term is not explicitly defined and could be broadly interpreted so as to exclude long-term treatment for substance use disorders, and other chronic mental illnesses, from parity protections.

Addiction is a chronic disease similar to other chronic diseases such as type II diabetes, cancer, and cardiovascular disease.[4] Recovery from addiction is a long-term process, and the appropriate duration of treatment for an individual depends on the type and degree of the patient's problems and needs.[5] Therefore, it is imperative that "long term care" be clearly defined so as not to limit parity protections to coverage for acute or time-limited MH/SUD care.

Our concerns are rooted in the fact that many state Medicaid programs currently have arbitrary limits on reimbursement for medications for addiction treatment, despite the fact that scientific evidence supports their use as part of long-term treatment.[6] For example, a May 2013 survey of state Medicaid programs found that eleven states had implemented lifetime limits on prescriptions for buprenorphine products for treatment of opioid dependence, ranging from 12 months to 36 months.[7] These limitations are not based on scientific evidence or clinical recommendations, and put patients at risk for relapse, overdose and death. Instead, national clinical practices guidelines recommend the following regarding length of treatment with medications for opioid use disorder:

- Methadone: "The optimal duration of treatment with methadone has not been established however it is known that relapse rates are high for most patients that drop out, thus long-term treatment is often needed. Treatment duration depends

on the response of the individual patient and is best determined by collaborative decisions between the clinician and patient."[8]

- Buprenorphine: "There is no recommended time limit for treatment with buprenorphine. Buprenorphine taper and discontinuation is a slow process and close monitoring is recommended. Buprenorphine tapering is generally accomplished over several months. Patients and clinicians should not take the decision to terminate treatment with buprenorphine lightly… Patients who relapse after treatment has been terminated should be returned to treatment with buprenorphine."[9]
- Naltrexone: "Data are not currently available on the recommended length of treatment with oral naltrexone or extended-release injectable naltrexone. Duration of treatment depends on the response of the individual patient, the patient's individual circumstances, and clinical judgment."[10]

Given current poor state of Medicaid coverage for these evidence-based therapies and the dire need for long-term, uninterrupted treatment for patients with addiction, we request CMS explicitly define the term "long term care" in the final rule. Moreover, we request CMS issue an "FAQ" that further elaborates on the exclusion of "long term care" from the definition of medical/surgical services and provide examples that clearly indicate it is not intended that long-term outpatient and medication treatment for a chronic disease, including addiction, to be excluded from parity protections.

- **Provide more detail on how parity applies to intermediate MH/SUD services.**

The final parity rule that applies to commercial coverage included a detailed discussion of intermediate services; that is those services such as residential treatment, partial hospitalization, and intensive outpatient treatment that don't fit neatly into an inpatient/outpatient classification. The final MHPAEA rule did not include a definition of intermediate services or an intermediate services classification, but was clear that parity applied to these services. This proposed rule applying parity to Medicaid and CHIP likewise does not include an intermediate services definition or classification, but instead would allow the regulated entity or state to assign intermediate level services to any of the classifications as long as those classifications are done in a consistent manner for medical/surgical and MH/SUD services. We believe that strong clarification in the finalized version of this rule stating that intermediate services must meet parity is needed. Clarification of intermediate services is especially critical if CMS moves forward with its intended approach to exclude long term care services from parity, as some intermediate MH/SUD services may be incorrectly excluded from parity protections if they are considered long term care services by MCOs or states. We don't necessarily believe that the number of classifications needs to be expanded to include intermediate services, but we believe that more clarity and/or scope protections for intermediate services are needed to ensure that they are appropriately covered by states and MCOs.

- **Strengthen the prescription drugs requirements, and make clear that the full range of MH/SUD medications must be covered under parity.**

  As mentioned above, Medicaid programs often impose discriminatory limits on medications for addiction, including lifetime limits on methadone and/or buprenorphine, prescription refill limits that do not reflect the chronicity of the disease, and more stringent prior authorization requirements.

  We appreciate the attention that CMS has paid recently to improving access to medications for addiction treatment, including last year's informational bulletin from CMS, CDC, SAMHSA, NIDA, and NIAAA that provided guidance to states to improve coverage for addiction medications under Medicaid.[11] The informational bulletin, like this proposed rule, clarified that prescription drug coverage must comply with the requirements of MHPAEA.

  We believe that parity, effectively implemented, will significantly improve patient access to medications for MH/SUD. However, effective implementation of parity for prescription drugs requires that states and MCOs have strict requirements that they must meet, and we urge CMS to strengthen parity requirements related to prescription drugs in the final rule. Specifically, we believe that parity requires that all approved medications for addiction be covered, especially considering how few medications are available to treat addiction. We ask for requirements in the final rule that ensure adequate access to all available medications for MH/SUD, without any more stringent limitations than those imposed on other medications. We also encourage CMS to prioritize prescription drug coverage in its enforcement of parity, and to monitor carefully claims data to identify and remedy any problems quickly.

- **Make public the methodology for compliance and issue clear guidance as to what plan documents and instruments must be provided and what level of information must be disclosed**, so that beneficiaries and providers may know if a plan is in compliance with these regulations.

  The proposed rule improves transparency by requiring Medicaid and CHIP coverage subject to the parity requirements to "make their medical necessity criteria for MH/SUD benefits available to any enrollee, potential enrollee, or contracting provider upon request." The proposed rule also notes that other consumer protections apply in Medicaid that require MCOs, PIHPs, and PAHPs to notify the requesting provider and enrollee of any decision to deny a service authorization or approve a service in an amount, duration, or scope that is less than requested. We appreciate these protections, but point out that only making information about MH/SUD services, criteria, and denials available without also providing the corresponding medical/surgical information is insufficient to determine parity compliance. We urge CMS in the final rule to explain in more detail what this rule and other regulations require related to disclosure, and to ensure that all information needed by providers, enrollees, and potential enrollees to determine parity compliance is fully available in a timely manner

Further, given the current compliance problems in the commercial market, particularly around disclosure, we believe plans and states need additional guidance to comply with and enforce MHPAEA fully. This is particularly important given the more complex parity analyses that will be required in states where MH/SUD services are provided through "carve-out" plans, separate from medical/surgical services.

While we appreciate that states that do not provide all services through the MCO will be required to provide evidence of compliance when they submit their MCO contracts for review and approval, we feel it is critical that there be explicit guidance as to what this evidence must comprise and a public methodology published for determining compliance, so that parity analyses are transparent and uniform across plans and states. We ask CMS to provide more details on what information states have to report and make public. CMS should also include more details on its oversight role, including what CMS requires from states to satisfactorily demonstrate parity compliance. We also urge CMS to require states to report their progress well in advance of the effective date of the final rule to allow for proper oversight and to ensure full compliance with parity beginning the day the regulations take effect. States should be required to make all of their reports public and CMS should make reports from all states available on Medicaid.gov as they are submitted.

In closing, ASAM thanks you again for the opportunity to offer comments on this important proposed rule. We appreciate the strong commitment CMS has made to improve access to MH/SUD services in Medicaid and CHIP and look forward to continuing to work with the Administration to improve access to evidence-based addiction treatment.

Sincerely,

R. Jeffrey Goldsmith, MD, DLFAPA, FASAM
President, American Society of Addiction Medicine

---

[1] Substance Abuse and Mental Health Services Administration. *Results from the 2013 National Survey on Drug Use and Health: Summary of National Findings*, NSDUH Series H-48, HHS Publication No. (SMA) 14-4863. Rockville, MD: Substance Abuse and Mental Health Services. Administration, 2014.

[2] Busch SH, Meara E, Huskamp HA, Barry CL. Characteristics of Adults With Substance Use Disorders Expected to Be Eligible for Medicaid Under the ACA.*Psychiatric services (Washington, DC)*. 2013;64(6):520-526.

[3] http://downloads.cms.gov/cmsgov/archived-downloads/SMDL/downloads/SHO110409.pdf

[4] National Institute on Drug Abuse. Drug Abuse and Addiction: One of America's Most Challenging Public Health Problems. June 2005. Available at: http://archives.drugabuse.gov/about/welcome/aboutdrugabuse/index.html

[5] *Ibid.*

[6] ASAM. Advancing Access to Addiction Medications: Implications for Opioid Addiction Treatment. 2013. Available at: http://www.asam.org/docs/default-source/advocacy/aaam_implications-for-opioid-addiction-treatment_final

[7] *Ibid.*

[8] ASAM National Practice Guideline for the Use of Medications in the Treatment of Addiction Involving Opioid Use. June 1, 2015. Available at: http://www.asam.org/docs/default-source/default-document-library/national-practice-guideline7ed60d9472bc604ca5b7ff000030b21a.pdf?sfvrsn=0

[9] *Ibid.*

[10] *Ibid.*

[11] http://www.medicaid.gov/federal-policy-guidance/downloads/cib-07-11-2014.pdf